

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN5901</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/05/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>NHC HEALTHCARE, LEWISBURG</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1653 MOORESVILLE HIGHWAY LEWISBURG, TN 37091</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments  A licensure survey and complaint investigation #40151 and #40769 were completed at NHC Healthcare of Lewisburg on 4/3/17 - 4/5/17. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE